Handbook For Market Plan Development

January 2003

Supplement to Chapter 5, CARES Guidebook – Phase II
Version I

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1.Introduction. The Handbook was created to serve as a supplement to Chapter 5 of the CARES Guidebook – Phase II. The Handbook provides additional detail on the planning and analysis required for the resolution of CARES Planning Initiatives and development of CARES Market Plans. Networks should fully review the contents of this document, as well as Chapters 5 and 10 of the CARES Guidebook – Phase II.

A. The CARES Evaluation Criteria, which are more fully described in Chapter 10, Attachment 10A of the CARES Guidebook, provide information on the level of detail that will occur in the VA Central Office review and evaluation of Network Market Plans.

The greatest emphasis in the rollout of CARES has been placed upon receiving the CARES baseline and projection data, selecting the Planning Initiatives (PI), and implementing the CARES Market Planning Template (also known as the IBM Application), so that cost and space considerations could be systematically and consistently analyzed. However cost and safety of the environment are only two of the seven evaluation criteria that will be used in the review and evaluation of CARES Market Plans. Networks must give full consideration to all of the criteria as they proceed.

The CARES Evaluation Criteria are divided into two components; Threshold and Impact Criteria. Failure to adequately respond to the Threshold Criteria of Health Care Quality (clinical) and Safety of the Environment will result in the return of the Market Plan prior to a full review.

The five (5) Impact Criteria were designed to assess the positive impacts of the Market Plans and describe strategies for minimizing negative impacts. It is important that negative impacts not be used to exclude solutions that are cost effective, enhance access and promote quality of care. The obligation in the Market Plan is to describe a strategy to minimize any negative impacts.

Potential DoD collaborative opportunities identified in the Planning Initiative selection process must be fully considered in the development of Market Plans. DoD collaboration, or reasons for any lack of collaboration, must be carefully documented in response to the CARES Evaluation Criteria. There is an expectation that VA/DoD collaboration will be moved forward through the CARES process and will be closely reviewed in the Market Plans.

B. Most of the components of the Network Market Plans will be entered into the CARES Market Planning Template, a computerized Internet based relational database that will provide a consistent system wide methodology for determining the operational and capital costs of alternative solutions to Planning Initiatives. Components of the Market Plan will be able to be accessed through reports from this database. However, additional information will also be required for the submission

and review of the Market Plans. Specifically, back-up documentation associated with the analysis of alternatives for the Planning Initiatives, as specified throughout this document, will be required as well as information on how the veteran and stakeholder input was considered and utilized in the resolution of the Planning Initiatives.

C. The Access, Small Facilities, Proximity, Capacity, Vacant Space PIs, and "all other CARES Categories" have different analytical and submission requirements. They reflect the different levels of complexity and expected internal and external scrutiny of the solutions proposed in the Market Plans.

2. Definitions:

- Planning Initiatives: A Planning Initiative (PI) is an identified future gap or overlap in healthcare services for a market area that met specific thresholds and that need to be resolved. This is:
    - Small Facility PI (those facilities projected to need less than 40 beds between now and the next 20 years)
    - Proximity PI (two or more facilities with similar missions within close proximity of each other) defined as acute or tertiary. The focus is to identify unnecessary duplication in services now and projected in the future.
    - Capacity PI (a large increase or decrease in workload i.e. Demand and Supply Gap)
    - Special Population PI as identified by the Special Population Planning Team
    - Vacant Space PI (significant vacant space remaining)

- Market Plan: A Market Plan is the blueprint for how VA will prepare for meeting the health care needs of veterans for the next 20 years. The Market Plan will include the resolution of the VACO/PI Team identified Planning Initiatives. Market Plan development is facilitated by using an Internet based relational database (Market Planning Template). The Market Planning Template will include the allocation of all workload and space for the CARES planning horizon.

  The Market Plan will include the following data:
    - Utilization data (by CARES Category, County, Treating Facility and Year)
    - Space Needs (by CARES Category, treating facility and year)
    - Capital Plans and Alternatives explored (by CARES Category, treating facility and year)
    - Workload Plans (contract, in-house, etc.) and Alternatives explored (by CARES Category, treating facility and year)
    - Impact on CARES Criteria (VISN, Market, Facility or PI level)

3. Market Planning Template

a. The Market Planning Template allows Networks to input their Market Plans using a consistent system-wide methodology for determining the operational and capital costs of alternative solutions to Planning Initiatives. The Template also enables the review of Market Plans from multiple viewpoints – facility, market, criteria, CARES Category, etc. The underlying data (utilization and space) in the Template can be updated as projections and costs change.

b. Although the Market Planning Template does not allow for more than one user to enter data at a time at a VISN level, it is important that at a facility planning level, consideration be given to the level of operational detail that is required for the plan. For this reason, cost and space calculators have been developed to assist with brainstorming and developing scenarios that will provide the level of planning required.

c. The resolution of each individual Planning Initiative requires exploration of alternatives as outlined in this document, with narrative entry into the Market Planning Template (including any supplemental supporting justification and analysis). However, a final selected alternative cannot be made without consideration of all PI resolutions within the VISN. In other words, the "best" solution to a Proximity PI may be in conflict with a "best" solution to a Small Facility PI, therefore, each final individual PI solution cannot be selected without consideration and integration with solutions from other Planning Initiative resolutions. The overall blending of all the PI solutions at the VISN level is input into the Market Planning Template. Up to 3 possible VISN level solutions will be input as workload allocations into the Market Planning Template by CARES category. As a result, VISNs must coordinate the allocation of workload associated with each PI resolution across the entire Network.

4. Access Planning Initiatives

a. Objective

- Improve access to care for enrolled veterans so that 70% of veteran enrollees are within Primary Care driving time guidelines **or** less than 11,000 Enrollees are outside the Primary Care Guidelines **and** 65% are within Acute Hospital and Tertiary Care driving time guidelines **or** less than 12,000 veteran enrollees are outside Hospital or Tertiary Care Guidelines.

Driving Time Guidelines:

TYPE OF CARE	Urban	Rural	Highly Rural
Primary Care	30 minutes	30 minutes	60 minutes
Inpatient Hospital Care (Med/Surg/Psych)	60 minutes	90 minutes	120 minutes
Tertiary Hospital Care	3-4 hours	3-4 hours	Within VISN

b. Assessment of Current Environment:

- Review county level access data (CARES Portal, VISN Reports: Workload Supply – Access by County) to determine areas in the market that do not meet access guidelines. This report also shows the number of enrollees currently residing in each of these counties.
- Review where the veterans live and are projected to live in future years, as well as the concentration of veterans, and determine area/county/zip code that appears to be underserved. (CARES Portal, VISN Reports: Demand – Enrollees and Market Pen by County)
- Review enrollment projections and trends and identify changes in veteran geographic locations out over the next 10 – 20 years. (CARES Portal, VISN Reports: Demand – Enrollees and Market Penetration by County)
- View your current facility inventory (CARES Portal, VISN Reports: Supply-Facility Listing)
- Review facility level projections to observe where veterans go for care now and how far they travel. (CARES Portal, VISN Reports: Demand – Facility Based Workload Details)
- Consider transportation/geographic barriers that veterans face in accessing care.
- Identify the community resources in the areas with access gaps. Determine if you have the ability to contract for care or if these areas are also underserved in the private sector and may require a VA presence.
- Determine if there are opportunities to consider for joint ventures with DoD or other collaborative opportunities. (CARES Portal, Index: DoD)
- Consider referral patterns and impact of any new proposed sites on existing facilities.
- Consider "border" facilities – work with neighboring VISNs.
- Using the tools provided, determine the best solution for addressing the access gap (this might be adding a new site of care, contracting for care, expanding scope of services at existing sites or another solution. (http://10.224.151.46/access)
- Review utilization projections to determine types of services veterans require now and in the future; for outpatient access issues, consider demand for mental health in addition to primary care and specialty care. (CARES Portal, VISN Reports: Gaps – Facility Based Workload Report I and II)
- Consider costs of operating the sites of care (CARES Portal, VISN Documents: Cost Calculator)

c. Analysis:

- Using information gathered in the Assessment of Current Environment above, identify potential locations for new sites of care (VA or contracted) or mission changes to current facilities and recalculate compliance with driving time guidelines:

Primary Care: Identify potential locations for new sites of care and use the Access Calculator (http://10.224.151.46/access) to determine if these locations improve the degree to which the VISN meets the access threshold of 70% enrollees within driving time standards for FY2012 and FY2022.

Hospital and Tertiary Care: Identify potential locations for new sites of care and ask your VSSC CARES Consultant to determine if the locations improve compliance with the access threshold of 65% enrollees within driving time standards for FY2012 and FY2022.
Once a list of potential areas within the market that would serve enough enrollees to improve the access gap has been identified, determine the best option for providing services based on what is available in the community, cost and any other unique factors based on the proposed location.

- For proposed new Community Based Outpatient Clinics (CBOCs), review compliance with VHA Directive 2001-060, "Veterans Health Administration Policy For Planning And Activating Community Based Outpatient Clinics."
  - New site >30 minutes from another primary care site.
  - Number of Current Priority 1-6 Users in a 3-year period = 1,300 or Number of Enrollees = 1,600
  - Priority 1-6 market penetration <25%.
  - Priority 1-6 Vet Pop >29% of total Vet Pop in proposed CBOC area.

- Develop feasibility and cost estimates for at least two (2) of the following facility level alternatives (Not listed in any particular order) (CARES Portal, VISN Documents: Cost and Space Calculator)

  Alternative Option #1 Community Contracts
  Alternative Option #2 Sharing Agreements (DoD, Affiliate)
  Alternative Option #3 New Site (Lease – VA Staffed or Contract Staff)
  Alternative Option #4 New Site (Build – VA Staffed or Contract Staff)
  Alternative Option #5 Expanded Scope of Services at existing sites
  Other Alternative
- The VISN will decide upon the preferred alternative based on the outcomes of the feasibility and cost of the various alternatives. Other markets/VISNs will need to be notified if workload is being moved to a new site of care.
- VISNs may propose any combination of the above options (examples: establish new access points, expand scope of services at existing sites and refer some workload to community). For combination options, the same questions apply as in the individual sections.

d. Submission Requirements:

- Narrative: A written narrative will be developed to outline the attributes of the alternatives analyzed and the reasons for choosing the preferred option. This

narrative will be input in the Market Planning Template at the Market Level for Access.

- Alternative Analysis: Complete Appendix A for alternatives considered.
- Data: Workload allocations associated with this PI will be entered into the Market Planning Template at the Network level, as a part of one of 3 possible allocation combinations (refer to section 3c –Market Planning Template -of this document). For Access Guidelines, the new % of enrollees within access guidelines for 2012 and 2022 will be entered by the user in the Access section of the Market Plan Template for only the option selected.

5. Small Facility Planning Initiatives

a. Objectives

- Assure appropriate quality* of patient care is provided in a cost-effective manner.
  - **Quality includes clinical proficiency across the spectrum of care, safe environment and appropriate facilities.*
- Ensure that VA acute care hospitals projected to have less than 40 beds are fully evaluated and that alternatives are developed that provide for a more efficient utilization of resources and ensure quality of care.
  - Assure that the Small Facilities review fully considers the role of the facility in meeting projected outpatient primary and specialty care demand
- Note: As a result of the analyses, it is expected that some facilities will realign acute beds (i.e., status quo for all sites will not be acceptable).

b. Assessment of Current Environment

- Consider the current mission of the facility and what the anticipated impacts are of demand projections for services in the market (CARES Portal, VISN Reports: Demand – Facility Based Workload Details)
- Determine if the mix of services at the facility are appropriate to the demand projections with respect to the objectives to provide acceptable quality of care that is cost-effective.(CARES Portal, VISN Reports: Clinical Inventory)
- Determine what other healthcare options are available to the patient population served.
- Determine what capital investments are needed to provide an appropriate environment of care given the current mission. Evaluate the condition codes of the facility, and the feasibility of correcting life safety issues. (CARES Portal – VISN Reports – Supply – Space)
- Evaluate the current patient satisfaction trends for this facility from the inpatient satisfaction survey (VSSC Web site, Reports: Customer Satisfaction Scores)

c. Analysis

Analyze each of the options below and consider impact on CARES criteria using the attached matrix (Appendix A). Options are not listed in any particular order. Specifically, access each of the bulleted components of the alternatives in your analysis.

Identify the year in which bed levels become critically low (e.g. a consistent downward trend of 40 beds or less), to pinpoint the timeframe for developing/phasing plans. Ensure that the recommended options support this timeframe.

Alternative Option #A: Retain Acute Beds

a) Can the facility reasonably assure proficiency is maintained for the entire process of care? (E.g. physician, nurse, support staff and care processes). Address the following:

1) External Review

- How has the facility faired with accrediting bodies and other external reviews. List any JCAHO Type One and consultative recommendations, sentinel events or other relevant recommendations from external reviews (e.g. CARF, CAP, GAO, OSHA, OIG) (Facility/VISN Data)

2) Demonstrate that volume and case mix are sufficient to support efficient provision of 24/7 care. Include:

- How will specialty coverage be addressed?
- How will skills of clinicians in ER/Urgent Care be maintained with respect to triaging patients for transfer?
- Are volumes sufficient to attract and fully utilize and maintain personnel and maintain skill levels appropriate to workload?
- For surgical procedures, are volumes sufficient to meet known minimum standards for quality
- For ICU beds, are volumes sufficient to maintain proficiency of staff and efficient coverage?

3) Evaluate current facility performance on the following inpatient measures: [As available, express these measures as Actual to Expected (A:E) Ratio (observed/risk-adjusted expected)]

- VHA performance measures (e.g., cardiovascular, ischemic heart disease, pneumonia) (source: VHA website, Performance Measures tech manual)
- ORYX measures where applicable
- Readmissions
- LOS
- Non-acute admissions (based on Interqual or similar standards)
- Non–acute bed days (based on Interqual or similar standards)

- NSQIP for surgical beds (three year average)
- Board Certified MDs
- Nursing staff turnover
- Mortality

b) Having assured maintenance of proficiency, can the facility reasonably demonstrate that care can be provided in a cost-efficient manner? Evaluate as appropriate:

- Cost per bed day of care in the bed section in comparison with VISN and VA national average. (CARES Portal, VISN Documents: Cost Calculator)
- Cost per DRG for top five highest volume DRGs in the bed section in comparison with VISN and VA national average. (VSSC Web site, Reports: Financial)
- Staff cost measures, particularly MD per FacWork and RN per FacWork and Med/Surg FTE per FacWork (ARC web site: UCR Reports 6, 7 and 11c)
- VERA cost measures, including cost per basic PRP (ARC web site, Reports: VERA)

c) Are there opportunities to increase inpatient workload through sharing agreements (e.g., with DoD), enhanced use, etc.? (CARES Portal, Index: DoD)

Alternative Option #B: Close Acute Beds and Reallocate Workload to Another VAMC

- What is the ability of referral center to absorb the workload in the future based upon the CARES projections?
- What is the impact on travel times for patients who will be referred to the new site? (Use MapPoint - Contact CARES Consultant)
- Does the additional workload assist the referral center with maintaining a program that is volume-dependent or supports an education mission?
- Does the additional workload result in improved or neutral cost-efficiency at the referral site? (CARES Portal, VISN Documents: Cost Calculator)
- Costs per bed day and DRG compared to alternate site of care (should facility be closed) (VSSC Web site, Reports: Financial)
- If acute hospital beds are closed, what is the impact on other clinical or administrative services/programs that remain at the facility (e.g. nursing home, ambulatory care, diagnostic services)?
- Are there opportunities to improve primary/specialty outpatient care at the facility, if expected demand and access guidelines permit?
- If acute hospital beds are closed, what is the impact on special disability programs?

Alternative Option #C: Close Acute Beds and Implement Contracting, Sharing, or Joint Venturing for workload in the community

- Is there a resource in the community (e.g., private hospital, DoD, other federal or state facility) that can provide the service at an acceptable level of quality? Describe outcome measures used to determine acceptable quality at alternate site (in addition to accreditation).
- Is it feasible to contract for care at Medicare rates or less? If not, what is the facility's best estimate of the percentage addition to Medicare rates that would apply?
- How do the costs for contracting compare to current costs (CARES Portal, VISN Documents: Cost Calculator)
- Is contracting proposed for any workload that is currently being referred to another VAMC? If so, what is the impact on volume (proficiency) and cost at the referral VAMC?
- What is the impact on travel times for patients who will be referred to the new site?
- If acute hospital beds are closed, what is the impact on other clinical or administrative services/programs that remain at the facility (e.g. nursing home, ambulatory care, diagnostic services)?
- Are there opportunities to improve primary/specialty outpatient care at the facility, if expected demand and access guidelines permit?
- If acute hospital beds are closed, what is the impact on special disability programs??

Alternative Option #D: Combination Option

VISNs may propose any combination of the above options (examples: close beds and refer some workload to VA and some to community). For combination options, the same questions apply as in the individual sections

Other Alternative not mentioned above.

d. Submission Requirements:

- Narrative: A written narrative will be developed responding to the attributes of the alternatives analyzed (as described by the bulleted components of each alternative option) and the reasons for choosing the preferred option. This narrative will be input in the Market Planning Template at the Facility Level for Small Facilities.
- Alternative Analysis: Complete Appendix A for alternatives considered.
- Data: Workload allocations associated with this PI will be entered into the Market Planning Template at the Network level, as a part of one of three possible allocation combinations (refer to section 3c –Market Planning Template -of this document).

6. Proximity Planning Initiatives

a. Statement of Objective

Identify opportunities for cost efficiencies in clinical and administrative services in facilities that are identified in the Proximity Planning Initiatives by eliminating unnecessary duplication. The task is to search for efficiencies and potential improvements in quality through mission changes and/or consolidation of services that would be implemented over time and further refined in subsequent planning and implementation cycles.

b. Assessment of Current Environment

- Determine current mission of each facility (CARES Portal, VISN Reports: Supply - Clinical Inventory)
- Determine how well the Market/Network meets the Access Guidelines (CARES Portal – VISN Reports: Supply – Access)
- Determine the veteran enrollee population base to support the continued maintenance of capacity at each facility with similar missions in each close proximity pair (e.g. enrolled veteran per hospital or tertiary care facility – Note: veteran enrollee population density may be considered as well)
- Determine how far most enrollees travel currently (Utilization Data, County to Treating Facility – Available via VSSC CARES Consultant after 1-6-02)
- Determine total volume of workload projected through the CARES planning horizon and impact on each of the facilities. (CARES Portal, VISN Reports: GAPS – Facility Based Workload Report 1 & 2).
- Determine the percentage of enrollees who go to both facilities currently and evaluate the extent to which both facilities serve the same veteran population.
- Determine the ability of one or more facilities to absorb the workload of the others. Consider space, site and staffing.
- Assess the current physical condition and capacity of both facilities (CARES Portal – VISN Reports – Supply – Space)
- Assess the Valuation of each facility (CARES – Other Links: AEW – Office of Asset and Enterprise Management)
- Analyze the current patient satisfaction trends for both facilities from the inpatient satisfaction survey? (VSSC Web site, Reports: Patient Advocate: Customer Satisfaction Scores)
- Evaluate current referral arrangements for each of the facilities, including what other facilities currently refer patients and for what services.

c. Analysis:

For acute care hospital proximity PIs, analyze each of the options described in this section. For tertiary care hospital proximity PIs, fully analyze at a minimum Alternative C and one additional alternative. For all proximity PIs, specifically, address each of the bulleted components of the alternatives in your analysis and consider the impact on CARES criteria using the attached matrix (Appendix A). Options are not listed in any particular order.

Alternative Option #A: Retain both facilities w/ no additional consolidations of services

- ✓ Utilize this option only if determined that closure of one facility is unacceptable per analysis

AND

- ✓ No additional consolidations of services are feasible per analysis.

- Provide full justification for why this option is supported by providing the analysis of the elements in Options #B and #C that justify no future consolidations and integrations, including an analysis of future workload that will support continued operations of facilities and programs.
- Identify the cost of expected future capital improvements required at each facility in order to maintain safety and quality of care.
- Demonstrate that care can be provided in a cost-efficient manner. Include cost per bed day of care in comparison with VISN and VA national average. (CARES Portal, VISN Documents: Cost Calculator)
- Identify opportunities to enhance services at each facility, including opportunities for VA/DoD sharing and/or other enhanced use alternatives that would help to make operations of both facilities a cost effective alternative.
- Analyze impact on CARES Criteria and determine how negative impacts can be minimized (See Appendix A):
  - Impact on Healthcare Quality & Need
  - Safety & Environment
  - Impact on Research & Academic Affairs
  - Support other Missions of VA (VBA, NCA, DoD)
  - Impact on Special Disability Programs
  - Optimizing Use of Resources

Alternative Option #B: Maintain only one of the two facilities (Eliminate one facility)

- Determine the impact on closure of either facility on access and determine how negative impact can be minimized. (CARES Criteria: HealthCare Quality as measured by Access) (Primary Care - CARES Portal – Other Links: Access Application, Acute and Tertiary Care – contact your VSSC CARES Consultant to calculate the new access)
- Determine if either facility can accommodate the expected future workload from the entire region being studied. This must include physical infrastructure, staffing and an assessment of the scope of services. (CARES Criteria – Safety & Environment & Healthcare Quality & Need) (CARES Portal – VISN Reports: Supply – Clinical Inventory & Supply – Space)

- Determine if a capital investment would be required for either facility to absorb the full projected workload. (CARES Criteria – Optimizing Use of Resources) (CARES Portal – VISN Reports: Supply – Space, and Other Links: Space & Functional Surveys)
- Determine impact on other services and programs located at each facility.
- Observe trends of workload to determine timing of possible total consolidation. (CARES Portal, VISN Reports: GAPS – Facility Based Workload Report 1 & 2)
- Compute costs if one property is sold vs. Capital costs at retained facility. (CARES – Other Links: AEW – Office of Asset and Enterprise Management. Capital Costs determined off line via Facility Engineers)
- Analyze impact on the following CARES Criteria and determine how negative impacts can be minimized (See Appendix A):
    - Impact on Research & Academic Affairs
    - Impact on staffing and Community
    - Support other Missions of VA (VBA, NCA, DoD)
    - Impact on Special Disability Programs
    - Impact on Clinical Health care quality.

Alternative Option #C: Maintain both facilities but consolidate services/integrate facilities

- Review the missions and current and projected workload at both facilities to see if consolidation of services makes sense. (VSSC Web Page, Reports, Workload, General Inpatient, Top Procedures & Outpatient Top Procedures).
- Utilizing the Clinical Inventory (CI), DSS and workload reports identify clinical services for potential review. One ways to limit the scope of review is to focus on high cost and low volume services. High Cost services include but are not limited to:
    - ❖ Invasive cardiology
    - ❖ Hemodialysis
    - ❖ Joint Replacement
    - ❖ Vascular Surgery
    - ❖ Neurosurgery
    - ❖ Interventional Radiology
    - Transplant Programs

- Determine if both facilities have similar High Volume and/or High Cost services. (CARES Portal, VISN Reports: Supply – Clinical Inventory)
    - Look at ways the high cost workload is being managed. If one facility is contracting the care, look at providing in-house at one or the other facility.
    - Evaluate volume (current and projected), quality, and cost for these identified services:
    - Volume: View trends of individual inpatient services for which workload demand is available and/or estimate projected workload

based on current ratios of workload and projected enrollee and BDOC numbers. Bed sections not projected to require at least 10 beds should be considered for closure or consolidation. (CARES Portal, VISN Reports: Demand – Facility Based Workload Details)

- Quality: Does either facility have any programs that do not meet VA quality standards (e.g. NSQUIP). Programs not meeting these standards should be considered for closure or consolidation.
- Cost:
  - By CARES Category, determine if one facility has a higher cost than the other. Determine if one or another facility is a cost outlier nationwide. (CARES Portal, VISN Reports: Supply – DSS Unit Costs)
  - Look at specific High Cost services costs at both facilities to see if consolidation would be cost effective. (VSSC Web Page, DSS: Inpatient & Outpatient)

- Administrative Services Consolidation: Evaluate and identify potential administrative and support services for consolidation. This may assist in identifying more vacant space to manage, which could then reduce operating costs. An example would be Warehouse Services – leasing space in between the 2 facilities, and then being able to sell/lease/EU land and or buildings at either or both sites may be cost effective.
  - Types of Services: (CARES Portal, Other Links: Space & Functional Survey Data)
  - Costs of Services: (VSSC Web Page, Reports, Financial)

- Analyze impact of clinical and administrative consolidations proposed on CARES Planning Criteria and determine how negative impacts can be minimized (See Appendix A):
  - Impact on Healthcare Quality & Need
  - Safety & Environment
  - Impact on Access
  - Impact on Research & Academic Affairs
  - Impact on staffing and Community
  - Support other Missions of VA (VBA, NCA, DoD)
  - Impact on Special Disability Programs

  Optimizing Use of Resources.

Other Alternative(s) not listed above

d. Submission Requirements:

- Narrative: A written narrative will be developed responding to the attributes of the alternatives analyzed (as described by the bulleted components of each alternative option) and the reasons for choosing the preferred option. This narrative will be input in the Market Planning Template at the VISN level and at the Facility Level.
- Alternative Analysis: Complete Appendix A for alternatives considered.

- Data: Workload allocations associated with this PI will be entered into the Market Planning Template at the Network level, as a part of one of three (3) possible allocation combinations (refer to section 3c –Market Planning Template -of this document).

7. Capacity Planning Initiatives (Demand and Supply Gaps)

a. Objective: Ensure capacity for meeting changing workload and utilization demand. The task is to search for opportunities for efficiencies and potential improvements in quality through mission changes and/or consolidation of services that would be implemented over time and further refined.

b. Assessment of Current Environment

If workload is increasing:

- Review total demand of workload in each year, not just the difference between baseline and projected. (CARES Portal, Gaps – Facility Based Workload Report I & II)
- Determine if you are able to provide in-house, or contract – looking at space & cost: (CARES Portal, Other Links: Space & Functional Database & CARES Portal, VISN Documents: Cost & Space Calculator).
- Review nearby sites of care to see if the workload can be referred to a different site. Look at the costs, space and impact on access. (CARES Portal, Other Links: Space & Functional Database & CARES Portal, VISN Documents: Cost & Space Calculator & http://10.224.151.46/access)
- Review consolidation of services/space in order to end up with contiguous vacant space – as in entire buildings and/or floors. This will make managing vacant space much easier. Need to include any renovations in the appropriate CARES category for capital costs. (CARES Portal, Other Links: Space & Functional Database)
- Determine if there are opportunities to consider for joint ventures with DoD or other collaborative opportunities. (CARES Portal, Index: DoD)
- Review all collaborative opportunities

If workload is decreasing:

- Consider the current mission of the facility and the anticipated impacts of demand projections for services in the market (CARES Portal, VISN Reports: Demand – Facility Based Workload Details)
- Determine if the mix of services are appropriate to the demand projections with respect to the objectives to provide acceptable quality of care that is cost-effective. Consider how the mix should be adjusted. (CARES Portal, VISN Reports: Clinical Inventory)
- Determine what other healthcare options are available to the patient population served.

c. Analysis: Consider the following alternatives as appropriate. For Capacity Planning Initiatives, only two (2) alternative solutions are required to be fully analyzed, one of which is the preferred solution. *Parenthetical Note:* This is different than the Small Facility and Proximity PIs, where all alternatives are to be fully analyzed. Options are not listed in any particular order.

If workload is increasing

Alternative # A: Consider managing the workload in-house

- Determine if space is available to accommodate the increased need: (CARES Portal, VISN Reports – Supply – Space)
- Determine if capital investments (renovation and/or new onsite) are required to accommodate the increased workload (CARES Portal, Other Links: Space & Functional Database)
- Determine if staffing is available. Are there any recruitment or retention issues related to this category of care.
- Determine if support services are available for increased demand (CARES Portal, VISN Reports – Supply – Clinical Inventory)

Alternative # B: Consider managing the workload via contract

- Determine if resources exist in the community to provide the care (CARES Guidebook- Phase II, Chapter 4, Figure 4D, Survey)
- Determine costs of contracting (CARES Portal, VISN Documents: Cost Calculator)

Alternative # C: Consider alternative methods of managing the workload – (Sharing, EU, other VA)

- Consider nearby DoD facility within the market area that could accept some workload. (CARES Portal, Index: DoD)
- Consider affiliates for possible sharing agreements.
- Determine costs.

Alternative # D: Establish new site of care to handle increase

- If space is not available at existing site, consider adding a new facility to handle the increased demand. (CARES Portal, VISN Reports – Supply – Space)
- Consider impact on access – did this Market have a PI for Access? (http://10.224.151.46/access)
- Determine if service can be provided remotely from support services (Primary, Specialty or Mental Health)

- Determine best method for acquiring space such as lease, enhanced use, new construction (CARES Portal, VISN Documents Cost & Space Calculator)
- Determine if staffing is available. Are there any recruitment or retention issues related to this category of care
- Determine costs.

Alternative Option #E: Combination Option

VISNs may propose any combination of the above options (examples: in-house, contract, sharing, new site). For combination options, the same questions apply as in the individual sections

Other Alternative(s): not mentioned above

If workload is decreasing.

Plan for consolidation of space, re-direction of staff and resources. Determine impact on support services and lesson the negative impact.

d. Submission Requirements:

- Narrative: A written narrative will be developed for each CARES Category, for each of the CARES evaluation criteria to outline the attributes of the two (2) alternatives analyzed and the reasons for choosing the preferred option. This narrative will be input in the Market Planning Template at the Facility Level, CARES Category.
- Alternative Analysis: Complete Appendix B for alternatives considered.
- Data: Workload allocations associated with this PI will be entered into the Market Planning Template at the Network level, as a part of one (1) of three (3) possible workload allocation combinations (refer to section 3c –Market Planning Template -of this document). In addition, at the facility level, at least two (2) alternatives for how to provide the care must be considered and input in the template (Contract, in-house, share, etc), and at least 2 alternatives for how to manage the space must be considered and input into the template (renovation, new construction, lease, etc)

8. Vacant Space Planning Initiatives

a. Objective:

- Define the methodology for identifying vacant space for this cycle and recommendations for future year calculations.
- Provide guidance to VISNs to manage vacant space and resolve the Vacant Space Planning Initiative to allow for consistent/uniform application across the VA.

- Provide guidance for reducing vacant space to assist in meeting the VISN Performance Measure of 10% reduction by 2004 and 30% reduction by 2005 as well as the CARES planning horizon.

b. Assessment of Current Environment:

- Identify current vacant space: Vacant space is as defined by the VISNs during the Space & Functional Surveys. This includes the space identified as swing space by the facilities. (2% of the total GSF is the standard allowed for swing space, and 15% is the standard allowed for common space.) Vacant space does not include common space (hallways, chases, elevators, stairwells, mechanical spaces, etc.). (CARES Portal, Other Links: Space & Functional Surveys)
- Determine projected vacant space. (CARES Portal, VISN Documents: Cost & Space Calculator)

  For 2002 and beyond, the vacant space will be calculated using:
  the Total Utilized DGSF,
  plus Swing Space,
  plus common space,
  minus the new calculated Total Utilized,
  minus the new calculated allowable Swing Space,
  minus the new calculated common space.
  (These calculations are internal to the CARES Planning Template.)

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- Determine facilities/buildings that require Historic Preservation Considerations. If a building is on the Register, or eligible for the Register, refer to Section 106 of the National Historic Preservation Act (Regulations Codified: 36 CFR Part 800) for regulations governing Historical properties. Ensure adequate time to incorporate these requirements in the Market Plan. (CARES Portal, VISN Documents: Historic Properties)
- Current valuation of the VA inventory (CARES Portal, Other Links: AEW – Office of Asset and Enterprise Management)
- Cost estimates for capital (CARES Portal, Other Links: Cost Estimating (FM))
- Become familiar with VA capital planning processes (http://vssc.med.va.gov/construction/CAPPROGHOMEV2.htm)

c. Analysis: Consider the following alternatives as appropriate and at a minimum, develop two (2) alternative solutions. For Space Planning Initiatives, only two (2) alternative solutions are required to be fully analyzed, one of which is the preferred solution. *Parenthetical Note:* This is different than the Small Facility and Proximity PIs, where all alternatives are to be fully analyzed. Options are not listed in any particular order.

Step 1: Classify Vacant Space as temporary or permanent: The goal is to eliminate vacant space. After all the CARES categories have been resolved, the

space projected to be vacant for each year should then be managed. As the workload projections vary over time, the space needs also vary. If workload goes down, then the space needs go down also. If the workload stays at the low level for the 20-year planning cycle, the space is permanently vacant. If the workload increases, and therefore space needs increase, the space may only be temporarily vacant.

- Temporarily vacant (Calculated by CARES Planning Template)
- Permanently vacant (Calculated by CARES Planning Template)

Step 2: Consolidate vacant space: Identify the type of vacant space as:

- Adjacent: Vacant space that is a portion of a building.

OR

- Stand Alone: Vacant Space that is an entire building.

Work with facility engineers and space planners to look at pending consolidations/relocations of services to free up larger areas of vacant space, as in whole buildings or floors to make the vacant space suitable for out leasing, demolition, donation, etc. Provide the VISN CARES Coordinator/Committee with amount of vacant square feet that is adjacent and amount of vacant square feet that is stand-alone. (The existing information can be acquired from the S&F Survey Database.) The facility engineer and space planner also need to provide any pending plans for consolidations/relocations of services that would change the amount of adjacent to stand alone or vice versa.

Step 3: Reduce permanently vacant space: Consider the following alternatives, using the CARES Criteria (CARES Guidebook, Chapter 10) and complete the alternative matrix to determine the "best" alternative for each year, as well as the appropriate year. An appropriate year would be when you have enough space (like an entire building or floor) where the alternatives make sense to be considered. In addition, consider the functionality and reuse scores in the Space & Functional Survey Database to determine the feasibility of developing the following alternatives. *These alternatives are in NO particular order***.**

- Alternative A: Outlease: (NOTE: *This option can also be utilized for temporarily vacant space*.) Out-leasing is the leasing of VA owned real property to public or private interests outside of VA. In such cases VA is the lessor. VA's out-leasing authority is cited in 38 U.S.C. 8122 and is limited to a term no greater than three years. The authority has been delegated to VA Medical Center Directors per VHA Directive 98-014. Medical Center Directors must determine if there is a VA, government, or public interest to be served by the proposed request and that the purpose is not adverse to the interests of the United States Government. The proposed out-lease must also be consistent with the mission and program responsibilities of the VA. All out-leases must be reviewed and concurred in by the Office of Regional Counsel prior to execution. The Office of Facilities Management Leasing Staff, and

the Capital Programs Staff in the VISN Support Service Center are available for advice and guidance as requested.

- Examples to consider for out-leasing:
  - Veterans Benefits space
  - National Cemetery Service space
  - Department of Defense space
  - Child Day Care Center
  - VSO space
  - Other non-profit organizations
  - Community Organizations
  - University
  - Other Medical Care Providers
  - Corporate Entities (if appropriate)

The VHA Directive governing out-leasing can be found at: http://www.va.gov/facmgt/standard/policy/198014.doc

- Alternative # B Divest: Unless disposal of real property is specifically legislated by Congress, VA's disposal authority is very limited. Consequently, for the vast majority of disposals, VA must determine that the property is excess to VA's needs and inform the GSA of its desire to dispose of it. The Secretary must approve the disposal and Congress must be notified. VA commences environmental and historical clearances after Secretarial approval to excess is made. Prior to selling the property on the open market, GSA must first clear the property through other federal agencies that might have an interest. This includes notification to HUD to determine if use by the homeless is suitable. If there is no federal interest, the property is offered to state or local governments before it is offered to private bidders. Per VA regulations, the property must be sold for an amount equal to fair market value. VA's proceeds will be limited to the amount of sale less carrying and disposal expenses incurred by GSA. In most cases the funds must be deposited into the Nursing Home Revolving Fund. The AEW Capital Management, L.P. surveys conducted by the Office of Asset and Enterprise Management in 2002 show options for use of the property, as well as a valuation of the property. The results of these surveys can be found at http://vaww.va.gov/budget/capital/eu/cares_valuation_reports/. To sell property, refer to guidelines available at: http://www.va.gov/facmgt/landmanagement/RPdisposal.doc.

- Alternative # C: Demolition: Use this option only if out-leasing or divesting of the property is not feasible, or use of the land is required. See CFR, Volume 2, Title 41, Chapter 101, Part 101-47: Utilization and Disposal of Real Property for regulations. Also, see Checklist for Demo of Buildings: http://vssc.med.va.gov/construction/PDFDocs/Docs/BldgDemoChecklist.pdf.

- Alternative # D: Enhanced Use (EU): Enhanced-Use Leasing is a mechanism for obtaining facilities and services for VA activities. Enhanced-Use Leasing

is a cooperative arrangement between the Department and the private sector (or another government entity) for the use of Department-controlled property. In this arrangement both the private sector and VA contribute something of value. VA may offer "non-cash" assets on a long-term basis (up to 75 years) such as unused land, facilities, or access to a revenue producing market. In return, the private sector may provide facilities for VA use or provide certain services or products to VA activities at no or reduced cost. To be effective, the cost to VA (and to the Government), including the value of the out-leased land, for obtaining the facilities or services must be less than any other means for acquiring such products or services. This program's authority rests with the Secretary of Veterans Affairs and therefore the Secretary of Veterans Affairs must authorize all delegations of that authority.

- Execution of Enhanced-Use Leases involve approval of a concept or business plan, a public hearing, competitive selection of a developer, two (2) oversight reviews by VA's Congressional Committees, and oversight review and approval by VA's internal CIB process and OMB concurrence for "significant" (over $4.0M value) projects. Guidance and assistance with the reviews and approvals is available from the Office of Asset Enterprise Management (004B), Capital Asset Management and Planning Service (CAMPS), within the Office of Facilities Management, in Central Office. See Interim Policy for Enhanced Use: http://vaww.va.gov/budget/capital/Interim_EU_Policy.pdf
- Review the forecasted veteran population who may be appropriate for Assisted Living in an Enhanced Use Leasing proposal" (VSSC Portal)

- Alternative #E: Donate: Use this option if real property is being donated. For regulations, see CFR, Volume 2, Title 41, Chapter 101, Part 101-47: Utilization and Disposal of Real Property for regulations.

Step 4: Reduce temporarily vacant space: Consider the following options using the CARES Criteria and complete the alternative matrix to determine the "best" alternative:

- Alternative # A Outlease (see Alternative # A under Step 3 above)
-
- Alternative # B. Reserve (Keep vacant for a time):
  - Use this option if there is underutilized space (Underutilized = A department is utilizing more space than needed).
  - Use this option to reserve this space for future use, as projected by the CARES Planning Template.
  - Use this option for programs not covered in the CARES Categories (For example: Expanded NHCU, Homeless, Long Term Care Alternatives, National Emergency Services, etc.)

c. Submission Requirements:

- Narrative: A written narrative will be developed for each of the CARES evaluation criteria to outline the attributes of two (2) alternatives analyzed and the

reasons for choosing the preferred option. This narrative will be input in the Market Planning Template at the Facility Level, CARES Category = Vacant Space. If any space is "reserved", a narrative justification is required.

- Alternative Analysis: Complete Appendix "D" for alternatives considered.
- Data: Workload allocations associated with this PI will be entered into the Market Planning Template at the Network level, as a part of one of 3 possible allocation combinations (refer to section3c –Market Planning Template -of this document). In addition, at the facility level, at least 2 alternatives for how to manage the space must be considered and input in the template (demolition, divest, out-lease, etc)

9. All other CARES Categories (Not identified as Planning Initiatives)

CARES market plans are to be used to develop the VA capital budget. In addition to capital requests that are derived from specific Planning Initiatives, the plans must have assessed all CARES category projections to determine the overall impact of workload forecasts on any future capital needs. This includes the FY 04 VA capital budget that must be consistent with CARES projections.

a. Objective:

- Ensure adequate and cost effective capacity for projected demand in each of the CARES Categories

b. Assessment of Current Environment:

- Determine how care is currently provided (CARES Portal, VISN Documents: Cost & Space Calculator)
- Determine if a capital investment is required due to poor quality of space (CARES Portal, Other Links: Space & Functional Database)
- Combine the bed section projections to look at the total bed changes in order to determine if you should consider the same options as in Small Planning Facility Planning Initiatives or in the Demand Supply Gap Planning Initiatives or if this would alter any future plans for capital.

c. Analysis:

- No alternatives are required for non-PI CARES Categories UNLESS a Capital Investment is proposed. If a Capital Investment is required, at least 2 alternatives must be considered for managing the workload (contract, in-house, sharing, etc) and for managing the space (renovate, new construction, lease, etc)
- If no capital investment is required, no further analysis is required.

d. Submission Requirements:

- Narratives: If a capital investment is required for the CARES Category, a written narrative for each of the CARES Criteria is required. If no capital investment is required, no narrative is required.

- Alternative Analysis: Complete Appendix D for Categories with a capital investment for alternatives considered.
- Data: Workload allocations associated with this PI will be entered into the Market Planning Template at the Network level, as a part of one of 3 possible allocation combinations (refer to section3c – Market Planning Template -of this document). In addition, at the facility level, at least 2 alternatives for how to provide the care must be considered and input in the template (Contract, in-house, share, etc), and at least 2 alternatives for how to manage the space must be considered and input into the template (renovation, new construction, lease, etc)
- If no capital investment is required, the user need not make ANY alterations of changes to the default Manage workload and space projections in the CARES Planning Template. The user can accept the projections and the CARES Planning Template will project costs based upon this "status quo" option. It will be assumed that the Network did NOT do any detailed planning for these categories

APPENDIX A
ACCESS/SMALL FACILITY/PROXIMITY

Criteria **Alternative**	**Healthcare Quality and Need**	**Safety & Environment**	**Healthcare Quality as Measured by Access**	**Impact on Research and Academic Affairs**	**Impact on Staffing and Community**	**Support other Missions of VA**	**Optimizing Use of Resources In-house**
Alternate A	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to minimize negative	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:
Alternate B	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:
Alternate C	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:

APPENDIX B

CARES CATEGORY/CAPACITY

Facility:

CARES Category:

Criteria **Alternative**	**Healthcare Quality and Need**	**Safety & Environment**	**Healthcare Quality as Measured by Access**	**Impact on Research and Academic Affairs**	**Impact on Staffing and Community**	**Support other Missions of VA**	**Optimizing Use of Resources In-house**
Contract	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:
Enhanced Use	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:
Sharing	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:
DoD Sharing	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:
Other	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:

APPENDIX C
Vacant Space PI

Facility:

Criteria Alternative	Healthcare Quality and Need	Safety & Environment	Healthcare Quality as Measured by Access	Impact on Research and Academic Affairs	Impact on Staffing and Community	Support other Missions of VA	Optimizing U of Resources In-house
Divest	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to mi neg. impact:
Demo	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to mi neg. impact:
EU	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to mi neg. impact:
Donate	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to mi neg. impact:
Out - lease	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to mi neg. impact:
Reserve	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:	Positive:
	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to min. neg. impact:	Strategy to mi neg. impact: